ARTICLE

A Tale of Two Taxes: Implementation of Earmarked Taxes for Behavioral Health Services in California and Washington State

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Objective: The authors sought to characterize perceptions of the impacts, attributes, and support for taxes earmarked for behavioral health services and to compare perceptions of the taxes among professionals in California and Washington, two states differing in earmarked tax designs.

Methods: Surveys were completed by 155 public agency and community organization professionals involved in tax implementation in California (N=87) and Washington State (N=68) during 2022–2023 (29% response rate). Respondents indicated their perceptions of the taxes' impacts, attributes, and support. Responses were summed as aggregate scores and were also analyzed as individual items. Bivariate analyses were used to compare responses of professionals in California versus Washington State.

Results: Earmarked taxes were generally regarded positively. Of the respondents, >80% strongly agreed that the taxes increased funding for services and were helpful, and only 10% strongly agreed that the taxes decreased behavioral health funding from other sources. Substantially more respondents in California than in Washington State strongly agreed that taxes' reporting requirements were complicated (45% vs. 5%, $p<0.001$) and that the taxes increased unjustified scrutiny of services or systems (33% vs. 2%, $p<0.001$). However, more respondents in California than in Washington State also strongly agreed that the taxes increased public awareness about behavioral health (56% vs. 15%, $p<0.001$) and decreased behavioral health stigma (47% vs. 14%, $p<0.001$).

Conclusions: Perceptions of the strengths and weaknesses of taxes earmarked for behavioral health services may vary by design features of the tax. Such features include stigma-reduction initiatives and tax spending and reporting requirements.

Psychiatric Services 2024; 75:410–418; doi: 10.1176/appi.ps.20230257

Inadequate funding is a barrier to providing and sustaining mental health and substance use (i.e., behavioral health) services, affecting care access, implementation, and outcomes (1–6). Amid rising public concern about behavioral health (7), earmarked taxes for behavioral health services have emerged as an increasingly common financing strategy (8).

An earmarked tax is one placed on a specific base (e.g., goods, property, or income), with the revenue dedicated to a specific purpose (9–12). A recent legal mapping study (8) identified 207 policies in the United States (96% at the county or city level) that earmarked taxes for behavioral health, finding that adoption of these taxes had increased over time. The study also found that these taxes generate about $3.57 billion annually and that approximately 30% of the U.S. population lives in a jurisdiction with such a tax. Substantial heterogeneity was also identified in the design of these taxes across jurisdictions (e.g., varying tax bases

HIGHLIGHTS

- Most of the professionals involved in implementing taxes earmarked for behavioral health in California and Washington State who were surveyed strongly agreed that the taxes improved systems and increased funding, access to services, and flexibility to address complex behavioral needs.
- A larger proportion of California versus Washington State respondents strongly agreed that the tax reporting requirements were complicated and that the earmarked taxes led to unjustified scrutiny of behavioral health services and systems.
- A larger proportion of California respondents than Washington State respondents strongly agreed that the earmarked taxes increased public awareness about behavioral health and decreased stigma about behavioral health issues.

TABLE 1. Key features of earmarked taxes for behavioral health services in California and Washington State

Feature	California	Washington State
Date enacted	Signed into law January 1, 2005	Signed into law May 17, 2005
Authorizing legislation description	Mental Health Services Act (AB 488) became law through state ballot initiative (Proposition 63).	"An Act Relating to the Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005" (E2SSB-5763); clarifications are provided in revised code of Washington State (RCW 82.14.460).
Tax design	1% tax on taxable household income exceeding $1 million	Counties can increase sales tax by .1% to fund new mental health services, substance use disorder services, and therapeutic courts for substance use disorder proceedings.
Tax orientation	Progressive	Regressive
Tax jurisdictions	Entire state	28 of 39 counties had adopted the tax in 2022.
Tax spending	Revenue is used to fund five components within every county: community services and support (required), prevention and early intervention (required), innovation (required), capital facilities and technological needs (optional), and workforce education and training (optional).	Counties have broad discretion regarding how tax revenue is spent, as well as the populations that are eligible for tax-funded services, with the exception that every county that adopts the tax must establish and operate a therapeutic court for substance use disorder proceedings.
Tax revenue generated	2021 gross tax revenue: $2,770,427,035 ($70.07 per state resident)	2021 gross tax revenue across all adopting jurisdictions: $173,676,029 (M=$23.83 per resident in implementing counties)
Oversight	State law requires that each county mental health program prepare and submit a 3-year program and expenditure plan to the state oversight bodies and provide annual updates. The oversight bodies are the California Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission.	Washington State Department of Revenue tracks revenue generated in adopting jurisdictions. Tax spending is not monitored by the state.

and rates, oversight, and spending requirements). As described in the legal mapping study and in a 2019 commentary on the topic (8, 12), the adoption of earmarked taxes for behavioral health in 2005 by California and Washington State substantially increased the proportion of the U.S. population covered by these taxes. As shown in Table 1, the taxes of these two states differ in policy design and implementation requirements.

CALIFORNIA'S "MILLIONAIRE'S TAX"

California's Mental Health Services Act (also known as Proposition 63) was signed into law in 2005 and increased the income tax rate by 1.0 percentage point for households with annual incomes exceeding $1 million. This tax revenue is collected by the state and allocated to all counties, according to a formula that accounts for population size and other county characteristics (13). The tax generated >$2.7 billion in fiscal year 2021 (about $70 per capita). Revenue is spent at the county level across specific categories (see Table 1). Among other spending requirements, counties are required to use a portion of the revenue for stigma-reduction initiatives. The California Department of Health Care Services and the California Mental Health Services Oversight and Accountability Commission monitor spending and the use of the funds. Studies (14–17) assessing the impact of the California tax on effectiveness outcomes have reported potential reductions in suicides, homicides, alcohol-related deaths, and stigma about mental illness. Several studies (18–20) have also documented improved outcomes related to adoption and sustainment of tax-funded services. However, perceptions of the tax among behavioral health professionals involved in its implementation have not been explored.

WASHINGTON'S 0.1% COUNTY SALES TAX INCREASE OPTION

Washington State law E2SSB-5763 was passed in 2005 and provides counties with the authority to raise their sales tax rate by 0.1 percentage points through a county ballot initiative to generate additional revenue for behavioral health services. In 2022, overall 28 of the 39 counties in Washington State had adopted the tax. These taxes generated >$173 million in fiscal year 2021 (about $24 per capita in implementing counties). In contrast to California, tax-adopting counties in Washington State have broad discretion over the behavioral health services funded with the taxes, with the only requirement being that some revenue is used to operate a therapeutic court for substance use disorder proceedings. Washington State has minimal state-level oversight of tax spending. In contrast to the state-level tax in California, few studies have evaluated the impacts of county behavioral health tax adoption—except for one study (21) that evaluated a county's tax-funded family treatment drug court.

PRESENT STUDY

Although previous research has documented the impacts of earmarked taxes on behavioral health outcomes (14–17), to our knowledge, no prior work has assessed perceptions of these taxes among behavioral health professionals involved in their implementation. Such perceptions hold promise for informing decisions about tax design and reform, as well as for uncovering potential unintended consequences. For example, research (22–24) on earmarked taxes for specific issues, such as transportation and education, has found that such taxes can ultimately decrease spending on the issue because of supplantation—the processes through which funding from other sources is reduced because of the new earmarked funding stream.

Using a survey of behavioral health professionals involved in earmarked tax implementation in California and Washington State, in this study we aimed to characterize perceptions of the taxes' impacts, attributes, and support and to compare these perceptions between respondents in California and Washington State. We focused on these two states because they both adopted earmarked taxes in 2005, yet the states differ in tax policy designs. This study was part of a larger project focused on taxes earmarked for behavioral health services (25).

METHODS

The methods for the survey findings presented here have been detailed in the protocol of the larger study (25) and were approved by the New York University Institutional Review Board. For all counties in California and for the 28 counties in Washington State that adopted the sales tax increases in 2022, we sought to identify behavioral health agency and other government and community organization officials involved in tax oversight, decision making, implementation, or service delivery (e.g., designated tax coordinators, directors of county mental health agencies, and members of county tax advisory boards). Respondents were identified through contact databases maintained by our practice partners (e.g., county professional associations), Internet searches, and databases of behavioral health officials compiled by a member of the research team (J.P.) for previous studies (26–28).

A Web-based survey was sent to these professionals in September–November 2022. Each person was sent a personalized e-mail with a unique survey link up to eight times. Telephone follow-up was conducted, and a $20 gift card was offered for survey completion. To capture the perspectives of professionals involved in earmarked tax policy implementation who were not included in our database, we also created an open (i.e., not unique) survey link that was circulated in February–March 2023 by our practice partners.

Unique survey links were completed by 62 of 200 professionals in California (31% response rate) and 51 of 194 professionals in Washington State (26% response rate). The aggregate unique survey link response rate was 29% (N=113 of 394), which was consistent with the rate for recent statewide surveys of behavioral health officials (26–28). The open link was completed by an additional 25 California respondents and 17 Washington State respondents. Therefore, the total sample size for this study was 155 (N=87 for California and N=68 for Washington State).

Measures

The survey instrument was pilot tested with subject matter experts before fielding. Survey items were developed on the basis of existing research about earmarked taxes (8–12, 22–24, 29–31), implementation science measures (32–34), and frameworks related to policy implementation (i.e., the exploration, preparation, implementation, and sustainment [EPIS] framework) (35). We assessed respondents' perceptions of the impacts, attributes, and external support for the earmarked taxes. Perceptions of the impacts of the taxes were assessed via 10 newly developed items, in which respondents rated the extent to which they agreed with statements about positive and negative tax impacts (ranging from 1, strongly disagree, to 7, strongly agree). Items focused on negative impacts were reverse coded, and responses were summed to create a continuous, aggregate positive impact score (Cronbach's $\alpha=0.82$).

We assessed perceptions of the attributes of the earmarked taxes via 10 items that spanned the five dimensions of "attributes of innovations" proposed in Rogers's diffusion of innovations theory (36): complexity, observability, trialability, compatibility, and relative advantage. These dimensions have been assessed via similar items in previous behavioral health policy research (37). Each dimension was assessed via two items, and respondents rated the extent to which they agreed with each statement (ranging from 1, strongly disagree, to 7, strongly agree). Items focused on negative attributes were reverse coded, and responses were summed across all dimensions to create a continuous aggregate positive attribute score (Cronbach's $\alpha=0.74$).

Perceptions regarding support for the earmarked tax were measured via five newly developed items that assessed the extent to which respondents perceived five groups (e.g., the general public and policy makers) as strongly supporting the earmarked tax (ranging from 1, completely disagree, to 7, completely agree). Responses were summed to create an aggregate support score (Cronbach's $\alpha=0.80$).

To characterize the sample, the survey also collected the respondents' basic demographic and occupational information. Respondents selected from the "actor" types, derived from Leeman et al.'s typology (38), to most accurately characterize their organization's role in tax implementation (e.g., providing services with tax revenue). Respondents also rated the extent to which they had been involved in seven activities related to tax implementation (e.g., strategic planning, service provision) (ranging from 1, not involved at all, to 7, very involved).

TABLE 2. Characteristics of survey respondents involved in implementation of taxes earmarked for behavioral health services, by state[a]

	Total (N=155)		California (N=87)		Washington State (N=68)		
Characteristic	N	%	N	%	N	%	p
Organization's role in tax implementation							
Delivery system organization: providing direct services with tax revenue	92	59	67	77	25	37	<.001
Support system organization: supporting system and capacity building efforts for organizations that provide direct services with tax revenue	77	50	46	53	31	46	.37
Synthesis and translation system organization: reviewing evidence about promising approaches to using tax revenue and communicating this information to organizations that provide direct services	49	32	33	38	16	24	.06
Individual role in tax implementation							
Strategically planning how tax revenue can be spent	88	63	57	70	31	53	.04
Establishing relationships with external partners related to the tax	88	62	55	68	33	55	.12
Making decisions about services to fund with tax revenue	89	62	56	68	33	54	.08
Monitoring how tax revenue is spent for compliance purposes	76	57	54	67	22	42	.01
Collecting or reporting information for compliance purposes	75	56	54	66	21	40	.004
Evaluating impacts of tax-funded services	74	54	47	60	27	47	.11
Directly providing tax-funded services	57	47	38	52	19	40	.18
Gender							
Female	96	62	61	70	35	52	.02
Male	44	28	19	22	25	37	.04
Nonbinary	0	—	0	—	0	—	—
Race-ethnicity							
Non-Hispanic White	115	74	61	70	54	79	.19
Hispanic	17	11	12	14	5	7	.20
Asian American	11	7	9	10	2	3	.08
Black or African American	6	4	4	5	2	3	.60
Native American or Alaska Native	3	2	1	1	2	3	.42
Years worked at current organization							
<1	1	1	0	—	1	2	.26
1–2	15	11	4	5	11	18	.06
3–5	25	18	12	15	13	21	.37
6–9	26	18	19	24	7	12	.06
≥10	75	53	46	57	29	48	.21
Highest level of education							
Some college	3	2	3	4	0	—	.12
College degree	39	28	15	19	24	39	.01
Master's degree	78	55	50	62	28	46	.04
Doctoral degree	22	16	13	16	9	15	.76

[a] Respondents were public agency and community organization professionals. df=1 for all analyses. Ns within subcategories may not add up to sample totals because of missing responses; percentages are based on totals within the main categories.

Analysis

To aid interpretability, items assessed on 7-point scales were dichotomized (yes or no) as "strongly agree" (rating ≥6) in the primary analyses and "strongly disagree" (rating ≤2) in post hoc analyses. (These items are also reported as continuous variables in the online supplement accompanying this article.) The proportion of respondents strongly agreeing with each statement was calculated, as well as means for aggregate scores, domain-specific attribute scores, and individual item scores. Chi-square and two-tailed independent-samples t tests were used to compare responses from professionals in California versus Washington State.

RESULTS

Table 2 shows the occupational and demographic composition of the sample. Most respondents identified their

TABLE 3. Perceptions of the impacts of taxes earmarked for behavioral health services among survey respondents involved in tax implementation, by state[a]

	Strongly agree (6–7 on 7-point scale)						
	Total (N=155)		California (N=87)		Washington State (N=68)		
Perceptions of the taxes' impact	N	%	N	%	N	%	p
Increases funding for direct behavioral health and social services	125	81	73	84	52	77	.25
Increases funding for improvements to behavioral health or social services systems	109	71	62	72	47	70	.79
Increases access to direct behavioral health and social services for people with the highest need	107	69	65	75	42	62	.08
Increases flexibility to address complex behavioral health and social service needs	104	68	56	64	48	72	.34
Increases the number of people served by evidence-based practices	97	63	56	64	41	61	.69
Increases transparency about behavioral health and social services systems	61	41	40	47	21	32	.07
[Does not] increase unjustified public or political scrutiny about behavioral health and social services systems[b]	65	44	23	27	42	65	<.001
[Does not] decrease funding from other sources (e.g., general county or state budgets) for behavioral health or social services[b]	91	62	49	59	42	66	.42
Increases public awareness about behavioral health issues	59	39	49	56	10	15	<.001
Decreases stigma about behavioral health issues	50	33	41	47	9	14	<.001

[a] The denominators of the percentages in this table are the numbers of professionals who responded to the item. Missing responses were excluded from the denominator, which therefore varies slightly across percentages. df=1 for all comparisons.
[b] Reverse coded; bracketed language has been added to aid interpretability and was not included in survey items.

organization's role as a delivery system actor providing direct behavioral health services with tax revenue (59%); a significantly larger proportion of respondents in California than in Washington State selected this organization type (77% vs. 37%, $p<0.001$). Most respondents had worked at their organization for ≥10 years. The proportion of respondents involved in planning how tax revenue could be spent was significantly higher in California than in Washington State (70% vs. 53%, $p=0.04$), as was the proportion of respondents collecting or reporting information for compliance purposes (66% vs. 40%, $p=0.004$). These differences likely reflected the more comprehensive planning and reporting requirements of the California tax.

Perceived Impacts of the Earmarked Taxes

More than 70% of respondents in both states strongly agreed that the taxes increased funding for direct behavioral health and social services (81% of the total sample) and for improvements to behavioral health or social systems (71% of the total sample) (Table 3). More than two-thirds of the respondents in the total sample strongly agreed that the taxes increased access to behavioral health and social services for people with the greatest need (69%) and increased provider flexibility to address complex behavioral health and social service needs (68%). Only 10% (N=16) of respondents in the total sample strongly agreed that the taxes decreased funding for behavioral health services from other sources, with no significant difference observed between the two states. No significant differences in these perceptions of impact were detected between respondents in California and Washington State.

No statistically significant difference was observed in mean aggregate positive impact score between California and Washington State respondents (mean=53.5 vs. 52.3, respectively; highest possible score 70.0). However, a substantially larger proportion of California versus Washington State respondents strongly agreed that the taxes increased public awareness about behavioral health issues (56% vs. 15%, $p<0.001$) and decreased stigma about these issues (47% vs. 14%, $p<0.001$). Among California respondents, 33% (N=28 of 84) strongly agreed that the taxes increased unjustified scrutiny for services and systems, compared with only 2% (N=1 of 65) of Washington State respondents ($p<0.001$). Almost two-thirds of respondents in both states strongly agreed that the taxes increased the number of people served by evidence-based practices, with no significant difference between the two states.

Perceived Attributes of the Earmarked Taxes

More than 80% of respondents in both states strongly agreed that it was better to have than to not have the taxes (Table 4). However, only 7% of respondents in the total sample strongly agreed that rules related to how tax revenue could be spent could be easily changed to address emergent needs; 52% (N=81) of the total sample strongly disagreed with this statement.

TABLE 4. Perceptions of the attributes of taxes earmarked for behavioral health services among survey respondents involved in tax implementation, by state[a]

	Strongly agree (6–7 on 7-point scale)						
	Total (N=155)		California (N=87)		Washington State (N=68)		
Perception of attributes	N	%	N	%	N	%	p
Relative advantage							
It is better to have the tax than not.	132	85	72	83	60	88	.34
The tax is better than alternative strategies to increase funding for behavioral health services.	60	40	41	48	19	29	.02
Compatibility							
The tax is flexible enough to allow behavioral health service organizations to meet the unique needs of the communities they serve.	67	44	34	39	33	50	.18
The tax is compatible with the financing structures of behavioral health service organizations.	56	38	35	42	21	33	.30
Complexity							
It is [easy] to understand what is and what is not a permissible use of revenue from the tax.[b]	74	48	30	35	44	66	<.001
It is [easy] to satisfy reporting requirements related to using revenue from the tax.[b]	54	36	12	14	42	66	<.001
Observability							
The impact of the tax on the number of people who receive services is easy to observe.	51	33	32	37	19	28	.23
The impact of the tax on the behavioral health status of communities is easy to observe.	48	31	27	31	21	31	.95
Trialability							
The tax allows behavioral health service organizations to try new services and assess whether they meet needs before taking the services to scale.	71	47	49	56	22	34	.01
The rules related to how revenue from the tax can be spent can be easily changed to address emergent needs.	10	7	6	7	4	6	.79

[a] The denominators of the percentages in this table are the numbers of professionals who responded to the item. Missing responses were excluded from the denominator, which therefore varies slightly across percentages. df=1 for all comparisons.
[b] Reverse coded; bracketed language has been added to the table to aid interpretability and was not included in survey items.

No statistically significant differences were detected in the mean aggregate positive attribute score between California and Washington State respondents (mean=46.3 vs. 47.8, respectively; highest possible score 70.0). However, significant differences were observed when ratings of individual attributes were dichotomized and compared. A significantly larger proportion of California respondents versus Washington State respondents strongly agreed that the taxes were better than alternative strategies to increase behavioral health funding (relative advantage attribute, 48% vs. 29%, p=0.02) and that the taxes allowed behavioral health organizations to try new services and to assess whether they met needs before scaling up the services (trialability attribute, 56% vs. 34%, p=0.01). By contrast, a significantly smaller proportion of California respondents strongly agreed that it was easy to understand permissible uses of the tax revenue (i.e., complexity: 35% vs. 66%, p<0.001) and that it was easy to satisfy tax reporting requirements (14% vs. 66%, p<0.001); 45% (N=39 of 86) of respondents in California strongly agreed that satisfying reporting requirements was complicated, compared with only 5% (N=3 of 64) in Washington State.

Perceptions of Support for the Earmarked Taxes

In the total sample, strong support for the taxes was perceived as being the greatest among state behavioral health agency officials (72%) and consumers of behavioral health services (70%) (Table 5). Support was perceived as lowest among state elected officials (52%) and the general public (46%). No significant difference was observed in support score between California and Washington State respondents (mean score=26.9 vs. 28.3, respectively; highest possible score 35.0). In California, however, a significantly larger proportion of respondents strongly agreed that there was strong support for the taxes among consumers of behavioral health services (78% vs. 60%, p=0.02), whereas a significantly smaller proportion strongly agreed that there was strong support for the taxes among elected officials: 54% versus 74% for local elected officials (p=0.01) and 39% versus 68% for state elected officials (p<0.001). Although not statistically significant, a larger proportion of California respondents versus Washington State respondents strongly agreed that there was strong support for the taxes among the general public.

TABLE 5. Perceptions of strong support for taxes earmarked for behavioral health services among survey respondents involved in tax implementation, by state[a]

	Strongly agree (6–7 on 7-point scale)						
	Total (N=155)		California (N=87)		Washington State (N=68)		
Perceptions of strong support	N	%	N	%	N	%	p
State behavioral health agency officials in my state	108	72	56	66	52	79	.08
Consumers of behavioral health services in my jurisdiction	107	70	68	78	39	60	.02
Local elected officials in my jurisdiction	94	63	45	54	49	74	.01
State elected officials in my state	77	52	33	39	44	68	<.001
General public in my jurisdiction	70	46	43	49	27	41	.3

[a] The denominators of the percentages in this table are the numbers of professionals who responded to the item. Missing responses were excluded from the denominator, which therefore varies slightly across percentages. df=1 for all comparisons.

DISCUSSION

To our knowledge, this study presents the first systematic assessment of perceptions of earmarked taxes for behavioral health services among professionals involved in tax implementation. We found that these taxes were perceived favorably by public agency and community organization professionals. The vast majority of respondents strongly agreed that the taxes increased funding for behavioral health, especially for people with the greatest needs, and increased flexibility to address complex service needs. Only a small proportion of respondents (about 10%) strongly agreed that the taxes decreased behavioral health funding from other sources, a potential drawback of earmarked taxes (22–24).

These results suggest that the proliferation of policies that earmark taxes for behavioral health could be a positive development in behavioral health financing (8). The positive appraisals of the tax among behavioral health professionals observed in the present study complement those of the general public. Previous research (39, 40) has found that most U.S. adults are willing to pay higher taxes to improve behavioral health systems. As such, states and counties will likely continue to consider adopting these taxes. This study's findings can inform features of tax design, and may have particular relevance to taxes earmarked for behavioral health crisis systems, because such financing approaches are increasingly being considered to support implementation of the 988 Suicide & Crisis Lifeline.

To illustrate, in April 2023, residents in King County, Washington State, voted in favor of a property tax increase earmarked to finance the construction of five crisis stabilization centers (41). As of May 2023, new telecommunication fees (similar to taxes) are being earmarked to finance 988 implementation in six states, and many states are considering similar legislation (42). Proposals also have been made to earmark recreational cannabis excise tax revenue for crisis services (43). Variations in perceptions of the taxes by respondents in California versus Washington State may illuminate potential strengths and weaknesses of different features of tax design that could inform these financing strategies.

For example, the finding that a substantially larger proportion of respondents in California than in Washington State (45% vs. 5%) strongly agreed that satisfying reporting requirements was complicated likely reflected the more prespecified components and detailed reporting and oversight requirements required by the California tax, compared with the Washington State tax (44). The finding that a much larger proportion of respondents in California than in Washington State strongly agreed that the taxes increased unjustified scrutiny for behavioral health services and systems (33% vs. 2%) may have been shown in reforms to the tax proposed by California's governor in 2023 for a 2024 ballot measure (45). The unjustified scrutiny finding was also consistent with the finding that a significantly smaller proportion of California respondents, compared with Washington State respondents, strongly agreed that elected officials in their state strongly supported the taxes.

The finding that approximately three times as many California respondents than Washington State respondents strongly agreed that the taxes increased public awareness about behavioral health and decreased behavioral health stigma was likely related to requirements for California counties to allocate a portion of tax revenue to stigma-reduction initiatives (9 CA ADC § 3725). These perceptions were also consistent with research (16, 17) finding that a statewide communication campaign funded by the taxes reduced stigma toward people with mental illness. The finding that a significantly larger proportion of California versus Washington State respondents strongly agreed that there was strong support for the tax among consumers of behavioral health services may have reflected that the California taxes generated substantially more revenue per capita and thus may have had more visible positive impacts on service systems.

This survey had some limitations. Although our survey response rate of 29% was consistent with recent statewide surveys of behavioral health officials (26–28), the sample may not have reflected the perspectives of all behavioral health professionals involved in implementation of the earmarked taxes. The types of professionals actively involved in tax implementation are not uniform across

jurisdictions, and we learned, via e-mail responses to the survey invitation, that many professionals invited to complete the survey were not involved in the tax implementation and did not feel that they had enough familiarity with the tax to complete the survey. Thus, our sample likely reflected the perspectives of professionals with substantive experience with implementation of the earmarked taxes.

Survey items were pilot tested, and aggregate scores had acceptable internal consistency and were informed by theory (e.g., Rogers's constructs of attributes of innovations [36] and the EPIS [35] framework) and by previous research on earmarked taxes (8–12, 22–24, 29–31). These items, however, were newly developed for the survey. As identified in systematic reviews (32–34), few measures focused on policy implementation have undergone robust psychometric testing.

CONCLUSIONS

From the perspective of professionals involved in implementation of taxes earmarked to support behavioral health in California and Washington State, these taxes appear to be a potentially positive development for behavioral health financing. Differences in perceptions between respondents in California and Washington—states with differing earmarked tax policy designs—suggest features to consider when developing similar taxes in other U.S. jurisdictions. Such features include requiring allocation of a portion of the tax dollars for stigma-reduction initiatives and clearly specifying tax spending and reporting requirements.

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This study was supported by NIMH grant R21-MH-125261. The authors thank the County Behavioral Health Directors Association of California and the Washington State Association of Counties for their support in fielding the survey and the professionals who took the time to respond to the survey.

The authors report no financial relationships with commercial interests.

Received June 6, 2023; revisions received July 24 and September 6, 2023; accepted September 18, 2023; published online November 7, 2023.

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